PRINTED: 08/03/2011 FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			- 0	MB NO. 0938-0391
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DAT	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 01		COMPLETED	
		155353			— 07/13/	/2011
			B. WING	ADDRESS, CITY, STATE, ZIP CO	NDE .	
NAME OF I	PROVIDER OR SUPPLIEF	R		LINCOLN ST	DE	
HICKOD.	V CDEEK AT CDEE	NSBUBC	l l			
HICKOR	Y CREEK AT GREE	INSBURG	GREEN	NSBURG, IN47240		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR	RECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF	OULD BE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
K0000						
	A Life Safety Co	ode Recertification and	K0000	This Plan of Correction	a constitutes	
	State Licensure	Survey was conducted by		the written allegation o		
		e Department of Health in		compliance for the defi		
		42 CFR 483.70(a).		cited. However, submis		
	accordance with	42 CFR 463.70(a).		Plan of Correction is no		
				admission that a deficient		
	Survey Date: 07	7/13/11		or that one was cited co This Plan of Correction		
				submitted to meet requ		
	Facility Number	: 000244				
	Provider Number: 155353			established by state and federal law.		
	AIM Number: 1			1444.		
	7 thvi rumber.	100200790		Hickory Creek at Gree	ensburg	
		D : 1:0 0 0 1		desires this Plan of Cor	-	
	1 *	Bugni, Life Safety Code		be considered the facili	ity's	
	Specialist			Allegation of Complian		
				Compliance is effective	on August	
	At this Life Safe	ety Code survey, Hickory		12, 2011		
	Creek at Greensl	burg was found not in				
		Requirements for				
	_	Medicare/Medicaid, 42				
		*				
	_	3.70(a), Life Safety from				
		0 edition of the National				
	Fire Protection A	Association (NFPA) 101,				
	Life Safety Code	e (LSC), Chapter 19,				
	Existing Health	Care Occupancies and				
	410 IAC 16.2.					
	110 1110 10.2.					
	This one store for	paility was datarminad to				
	1	acility was determined to				
		22) construction and fully				
	_	e facility has a fire alarm				
	system with smo	oke detection in the				
	corridors, spaces	s open to the corridors,				
	_	n smoke detection in all				
	_	g rooms. The facility has				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

SGR521

Facility ID:

000244

If continuation sheet

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV O1 COMPLETE				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155353	A. BUILDIN	G	01	07/13/2	
		100000	B. WING	DEET AL	DDRESS, CITY, STATE, ZIP CODE	0771072	011
NAME OF F	PROVIDER OR SUPPLIER				LINCOLN ST		
HICKOR	Y CREEK AT GREE	NSBURG			SBURG, IN47240		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	- 1	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PRE	- 1	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TA	NG	DETICIENC!)		DATE
	the time of this v	and had a census of 32 at					
	the time of this v	ISIL.					
	Quality Review by I	Robert Booher, Life Safety					
		dical Surveyor on 07/15/11.					
	The facility was	found not in compliance					
	with the aforeme	ntioned regulatory					
	requirements as e	evidenced by the					
	following:						
K0027 SS=E	a 20-minute fire pr least 1¾-inch thick Non-rated protecti 48 inches from the permitted. Horizor with 7.2.1.14. Doc automatic closing 19.2.2.2.6. Swing to swing with egre- not required. 19	smoke barriers have at least obtection rating or are at a solid bonded wood core. We plates that do not exceed bottom of the door are not alsoliding doors comply ors are self-closing or in accordance with ing doors are not required as and positive latching is 1.3.7.5, 19.3.7.6, 19.3.7.7 action and interview, the	K0027	7	K-0027		08/12/2011
		ensure 1 of 2 sets of					
	smoke barrier do movement of smoke barriers sh 8.3.4. LSC 8.3.4 smoke barriers sh leaving only the necessary for prodefined as 1/8 incomplete.	ors would restrict the oke for at least 20 0.3.7.6 requires doors in nall comply with Section 1.1 requires doors in nall close the opening minimum clearance oper operation which is ch. This deficient fect 16 residents who			1. What corrective action(s) wis accomplished for those resident found to have been affected by deficient practice? It is the policy of this facility to ensure safet to all residents throug smoke barrier doors which restrict the movement of smoke for	tts the	

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155353	A. BUII	LDING	nstruction 01	(X3) DATE SURVEY COMPLETED 07/13/2011	
	PROVIDER OR SUPPLIER		B. WIN	1620 N	DDRESS, CITY, STATE, ZIP CODE LINCOLN ST SBURG, IN47240		
				<u> </u>	3BURG, IN47240		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		X5) LETION
TAG	· ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	E	TE
_					at least 20 minutes.		
	Findings include	·			No residents were		
	i mamgs merade	•			- (0 - 02-02-02-02 () 0 - 0		
	Based on observ	ation on 07/13/11 at			affected by this pract	I	
	12:10 p.m. with				On July 13th, 2011 th	e	
	*	East Hall set of smoke			East Hall set of smoke		
	•	l a one inch gap where the			barrier doors were		
		t. This was verified by			adjusted to close and		
	the maintenance	supervisor at the time of			latch as required.		
	observation.				meen us required.		
	3.1-19(b)				2.How other residents having potential to be affected by the same practice will be identified and what corrective action(s) are taken? On July 13, 2011 other smoke barrier doors were checked for proper closure and latch requirements to ensure safety residents. No other residents have been affected since that date. If the Maintenance supervisor Administrator finds that any of smoke barrier doors are not class required, they will be repairs to that they do close completel soon as possible.	L vill of all ave or f the osed ed	
					3.What measures will be into place or what system changes will be made to		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	T OF DEFICIENCIES OF CORRECTION	identification number: 155353	A. BUILDING B. WING	01	COMPL 07/13/2	ETED
	ROVIDER OR SUPPLIER		STR 162	EET ADDRESS, CITY, STATE, ZIP CO 20 N LINCOLN ST EENSBURG, IN47240	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAC	CROSS-REFERENCED TO THE A	HOULD BE	(X5) COMPLETION DATE
				ensure that the del		
				Maintenance Supervise the smoke barriers does closure and latch 5 times for 30 days, 3 times a wanother 30 days, and to once a week on an on-He will log his checks are sulting repair work that time on his prevent maintenance log. He was report any needed repart any needed repart and needing for her review described does not recurred to ensure the practice does not recurred to ensure the smoke barrier door documentation of thos the monthly QA&A Comeeting for the next for review and recomment QA&A Committee mado away with the compression of the smoke check documentation review discontinued by the continued by the cont	sor will check ors to ensure nes a week week for hen at least going basis. and any needed at netive vill also airs to the next anagement v. action be ne deficient r and what nee? ervisor will a checks of rs and the nee checks to nommittee of days for dation. The next of the next sis e barrier shows 100% on the next of the next	
				Maintenance Supervis	or will	

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155353	(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 01	(X3) DATE S COMPLE 07/13/2 0	ETED
	PROVIDER OR SUPPLIER Y CREEK AT GREE		P. W.	STREET AI	DDRESS, CITY, STATE, ZIP CODE LINCOLN ST SBURG, IN47240		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
mo	REGULTION OF	ESC IDENTIFICATION INCOMPLETION		mo	and documentation of them on ongoing basis. Date of Compliance: August		DALE
K0029 SS=E	fire-rated doors) of extinguishing system and/or 19.3.5.4 provided with the approve extinguishing system are separated from resisting partitions self-closing and not protective plates the from the bottom of 19.3.2.1 Based on observations of accility failed to the sextension of the	d construction (with ¾ hour an approved automatic fire em in accordance with 8.4.1 otects hazardous areas. d automatic fire em option is used, the areas in other spaces by smoke and doors. Doors are on-rated or field-applied that do not exceed 48 inches the door are permitted.	K	0029	K-0029 1. What corrective action(s) wi accomplished for those residen	ill be	08/12/2011
	were provided w self closing device the doors to auto- into the door france practice could after reside on the East room and kitcher Findings include Based on observate a tour of the facil 12:40 p.m. with the supervisor, the sek kitchen door and	ntion on 07/13/11 during ity from 10:10 a.m. to			found to have been affected by deficient practice? It is the policy of this facility to ensure safet to all residents throug smoke barrier doors which restrict the movement of smoke for at least 20 minutes. No residents were affected by this praction of July 13th, 2011 the Maintenance Supervise adjusted the boiler roce.	the y ch	

000244

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155353	(X2) M A. BUII B. WIN	LDING	NSTRUCTION 01	(X3) DATE SURVEY COMPLETED 07/13/2011
	PROVIDER OR SUPPLIEF			1620 N	DDRESS, CITY, STATE, ZIP CODE LINCOLN ST SBURG, IN47240	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	were located did	not fueled water heaters not close completely. nch gap and failed to			door to properly close and latch as required.	
	close and latch e	ach door. This was naintenance supervisor at			The automatic door closure for kitchen door has been ordered will be installed on July 25th, 2	l and
	3.1-19(b)				2.How other residents having to potential to be affected by the same practice will be identified and what corrective action(s) where taken? On July 13, 2011 other smoke barrier doors were checked for proper closure and latch requirements to ensure safety residents. No other instances on noncompliance were identified	r of all
					If the Maintenance supervisor Administrator finds that any o smoke barrier doors are not cl as required, they will be repair so that they do close completel soon as possible.	or of the losed red
					3.What measures will be into place or what system changes will be made to ensure that the deficient practice does not recur? Maintenance Supervisor will come the smoke barriers doors to en	check

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155353	(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 07/13/2011
	PROVIDER OR SUPPLIEF		1620 N	ADDRESS, CITY, STATE, ZIP CODE LINCOLN ST NSBURG, IN47240	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	COMPLETION DATE
				closure and latch 5 times a week for 30 days, 3 times a week fanother 30 days, and then at once a week on an on-going. He will log his checks and ar resulting repair work needed that time on his preventive maintenance log. He will also report any needed repairs to Administrator at the next scheduled morning manager meeting for her review. 4. How will corrective action monitored to ensure the definition practice does not recur and OA will be put into place? The Maintenance Supervisor bring the results of his check the smoke barrier doors and documentation of those check the monthly QA&A Committee the monthly QA&A Committee may decing for the next 60 days review and recommendation QA&A Committee may decing for the smoke barrier check documentation shows compliance. Even though the documentation review is discontinued by the committee may decing the smoke barrier check documentation review is discontinued by the committee may decing the smoke barrier documentation review is discontinued by the committee may decing the smoke barrier check documentation of them ongoing basis. Date of Compliance: Augus 2011	or least basis. by dat of the ment least basis. by dat of the ment least be cient what least of the least basis. The de to be cier 100% be least basis on an least basis least

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUIL			ONSTRUCTION 01	(X3) DATE : COMPL	ETED	
		155353	B. WIN	G		07/13/2	011
	PROVIDER OR SUPPLIER		1	1620 N	ADDRESS, CITY, STATE, ZIP CODE LINCOLN ST ISBURG, IN47240		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DROWING DEAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	-	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	I C	DATE
K0050 SS=C	Fire drills are held varying conditions, shift. The staff is fis aware that drills routine. Responsit conducting drills is competent persons exercise leadership conducted betwee announcement manualible alarms. Based on record of facility failed to each shift for a past year. This did all resident in the Findings include: Based on review Fire Drill Log Bosupervisor on 07/drills conducted of the year 2010 to a following dates a 3:00 p.m., 05/27/at 3:05 p.m., and The fire drills confrom the year 2010 to a following dates a 4:30 a.m., 06/00/30/10 at 4:50 a 4:57 a.m. Based on an interpretation.	at unexpected times under at least quarterly on each amiliar with procedures and are part of established bility for planning and assigned only to s who are qualified to p. Where drills are in 9 PM and 6 AM a coded by be used instead of 19.7.1.2 review and interview, the ensure fire drills were end times at least quarterly 2 of 3 shifts during the efficient practice affects affects affective. The control of the Report of Monthly book with the maintenance of 13/11 at 10:15 a.m., fire on the second shift from 2011 were held at the and times; 03/02/11 at 11/29/10 at 2:35 p.m. inducted on third shift 10 to 2011 were held at the estand times; 03/29/11 of 11/29/11 at 4:00 a.m., a.m., and 12/30/10 at	K	0050	K-0050 It is the policy of the facility to ensure fire drills a conducted at unexpected ti at least quarterly on each s 1. What corrective action(s) will be accomplished for the residents found to have be affected by the deficient practice? The Maintenance Supervisor has been re-trai by the Administrator on the need to schedule unannour fire drills at unexpected and random times on each shift least quarterly. 2. How other esidents having the potent to be affected by the same practice will be identified at what corrective action(s) with be taken? The Maintenance Supervisor has examined the fire drill schedule from this time forward to make sure the unannounced fire drills are scheduled at different and unexpected times on each state least quarterly. The Administrator will review the schedule each quarter to ensure that this occurs as	are mes hift.) ose en - ned - nced d at er tial he that	08/12/2011

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CC		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED
		155353	B. WING		07/13/2011
NAME OF F	ROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE	
TO LINE OF T	NO VIDEN ON SOLVEIEN		l l	LINCOLN ST	
	Y CREEK AT GREE			NSBURG, IN47240	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	TAG		DATE
	,	econd shift times run		required. 3. What measure will be put into place or wh	
	from 3:00 p.mt	o 11:00 p.m., and third		systemic changes will be n	
	shift runs from 1	1:00 p.m. to 7:00 a.m.		to ensure that the deficient	
	The fire drills he	ld at similar times on		practice does not recur?	=
	second and third	shift were verified by the		Maintenance Supervisor wi	11
		ervisor at the time of		bring the Fire Drill schedule	
	record review.			and documentation of	
	10001d 10 view.			completed fire drills to the	next
	2.1.10(1.)			scheduled morning	
	3.1-19(b)			management meeting for	
				review and recommendatio	
				of process improvement. H	I
				will also bring the results o	I
				fire drills so that the IDT ca	
				review the results, identify improvement needs, and	any
				implement a plan according	nlv
				This activity will continue of	
				an ongoing basis. 4. How	
				corrective action be monitor	
				to ensure the deficient prac	
				does not recur and what Q	<u>4</u>
				will be put into place? The	
				Maintenance Supervisor wi	
				bring the quarterly fire drill	
				schedule to the QA&A	
				Committee meeting at least	
				quarterly for review. He will also bring the results of the	
				drills so that the Committee	
				can review and recommend	
				any interventions that are	
				needed for improvement. T	he
				Maintenance Supervisor wi	I
				follow up and bring back th	ie
				results improvements that	
				were implemented as a res	ult
				of the committee's	_
				recommendations at the ne	ext

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155353	(X2) MULTIPLE CO	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 07/13/2011
NAME OF E	PROVIDER OR SUPPLIER		B. WING STREET A	ADDRESS, CITY, STATE, ZIP CODE	
	Y CREEK AT GREE			LINCOLN ST ISBURG, IN47240	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	· [(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
	(EACH DEFICIEN			PROVIDERS PLAN OF CORRECTION (REAC CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) Scheduled quarterly meetir This will continue on an ongoing basis. Date of Compliance: August 12, 26	COMPLETION DATE